FAMILY IN NEED OF SERVICES: PRENATAL SERVICES

FAIRFIELD COUNTY PROTECTIVE SERVICES
REFERRAL FORM
Email to: FairfieldPCSAScreening@jfs.ohio.gov or Fax: 740.687.7070

Expectant Mother's First & Last Name: _____

DOB: _____ SS#: _____

Is the expectant mother a resident of Fairfield County: ___yes ___no

Address: _____

City: _____ Zip Code: _____ Phone Number: _____

What trimester is the expectant mother currently in: _____

Did the expectant mother have a prenatal positive screening for an illegal substance: ___yes ___no

What substance(s) was the expectant mother positive for: _____

Is the expectant mother currently engaged in any substance use treatment programs: ___yes ___no

If yes, who are they receiving services through: _____

Is the expectant mother engaged in prenatal care with a healthcare provider: ___yes ___no

If yes, who is the medical care provider/facility: _____

Has the expectant mother had previous pregnancies: ___yes ___no Previous births: ___yes ___no

Are there any children residing in the expectant mother's home whom she holds custody of: __yes __no

Does the expectant mother have a current Plan of Safe Care: ___yes ___no

What services or support would the expectant mother like to receive by working with Fairfield County Protective Services:_____

_____

Form Completed by: _____ Contact Info: _____

By signing below, I acknowledge I am requesting to have an open voluntary case with Fairfield County Protective Services. I understand this is a voluntary service available to me in which Fairfield County Protective Services will provide me with early intervention services to link me with substance use services, develop a Plan of Safe Care and to strengthen my supports prior to the delivery of my baby.

Printed Name: _____

Signature: _____ Date:_____

Witness: _____ Date: _____